

Form II.A.

Plan Information

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|---------------------|-------------------------|
| Legal Name of Plan: | Plan ID Number: 933- |
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|-------------------|------------------|-----------------|
| Reporting Period: | Reporting Month: | Reporting Year: |
|-------------------|------------------|-----------------|

Instructions: For each contracted provider the plan provided PPE, please complete a separate Form II.A.; use as many duplicates of Form II.A. as needed to represent all contracted providers who received PPE during this reporting period.

Item II.A.

1. Name of contracted provider:

| 2. Type of COVID-19 Supply (click): | 3. Amount Provided (units): | 4. Dates Provided (month/date/year): |
|-------------------------------------|-----------------------------|--------------------------------------|
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Respiratory (masks, etc.)

Eye (shields, visors, etc.)

Hand (gloves, etc.)

Other (disposable clothing, sleeve protector, aprons, etc.)